

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04159

4154

CERTIFICATE OF DEATH

Reg. Dist. No.

202

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>KENT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESTERTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MILLINGTON x0</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent Queen Anne's Hosp.</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Nathaniel R. BAKER</u>		4. DATE OF DEATH Month Day Year <u>April 1, 1957</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 4, 1892</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GARAGE</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GARAGE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GARAGE</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>WILLIAM BAKER</u>		14. MOTHER'S MAIDEN NAME <u>MARY LINGO</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>218-14-1851</u>	
17. INFORMANT <u>MRS. MAUDE BAKER</u>		Address <u>MILLINGTON, MD.</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u> <u>years</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fulminating Pneumonia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. ft. p. m. Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 27, 1957, to April 1, 1957 that I last saw the deceased alive on April 2, 1957, and that death occurred at — M, from the causes and on the date stated above.

ADDRESS (Street, city or town, state) DATE SIGNED
Thomson J. Tolow M.D. Chestertown, MD
ACTUAL SIGNATURE
PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4/3/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MILLINGTON CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>MILLINGTON, KENTCO. MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Holloway</u>		24a. REC'D BY REGISTRAR <u>APR 5 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Clara S. Barnes</u>

APR 5 1957

RECEIVED

4155

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH o. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. LENGTH OF STAY IN 1b life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Thomas Spencer Biddle				4. DATE OF DEATH Month April Day 28 Year 1957			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 13, 1878	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months 7 Days 9 Hours 19 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY owner	
11. BIRTHPLACE (State or foreign country) Kent Co. Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME George Spencer Biddle				14. MOTHER'S MAIDEN NAME Sarah M. Usilton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 0		16. SOCIAL SECURITY NO. 218-20-4689		17. INFORMANT Mrs. Estelle Strang		Address Rock Hall, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage z DUE TO Arteriosclerosis z Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 331x DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Ruptured appendix on 3-15-57							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Chestertown, Md.				20g. (County) (State)			
21. I certify that I attended the deceased from 3-15 , 19 57 , to 4-28 , 19 57 , that I last saw the deceased alive on 4-28 , 19 57 , and that death occurred at 9:10 p. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED 4-29-57							
ACTUAL SIGNATURE A. C. Dick				M.D. Chestertown, Maryland			
PHYSICIAN'S NAME (Type) A. C. Dick				Chestertown, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 1, 1957		22c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		22d. LOCATION (City, town, or county) (State) Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Wells Wells				ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR DATE Apr 30 1957	
				24b. REGISTRAR'S SIGNATURE Clara L. Barnes			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU ONE 10
 CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		MAY 1957	
AGE		SEX	
65		Male	
RACE		COLOR	
White		White	
BIRTH DATE		BIRTH PLACE	
MAY 1892		Maryland	
MARRIAGE DATE		MARRIAGE PLACE	
JAN 1915		Maryland	
OCCUPATION		CAUSE OF DEATH	
Farmer		Heart Disease	
EDUCATION		PLACE OF DEATH	
High School		Home	
RELIGION		DATE OF BURIAL	
Roman Catholic		MAY 20 1957	
PREVIOUS ILLNESS		DATE OF INTERMENT	
None		MAY 20 1957	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
J. H. Harris		J. H. Harris	
DATE		DATE	
MAY 19 1957		MAY 19 1957	

RECEIVED
 MAY 2 1957
 BUREAU V. 8

4161

CERTIFICATE OF DEATH

Reg. Dist. No.

200

1. PLACE OF DEATH o. COUNTY <u>KENT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>KENT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GALENA</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>GALENA XI</u>			
				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>SAMUEL</u> First <u>T.</u> Middle <u>DESHANE</u> Last				4. DATE OF DEATH Month <u>APRIL</u> Day <u>28</u> Year <u>1957</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 7, 1884</u>	
				9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>ALFRED T. DESHANE</u>				14. MOTHER'S MAIDEN NAME <u>ANN DYRE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				17. INFORMANT <u>MRS. ANN ELIZABETH DESHANE</u> Address <u>GALENA MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart</u> DUE TO <u>350x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Paralysis</u> DUE TO <u>Paralysis Cerebralis</u> (c) <u>Paralysis Cerebralis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>March 10, 1957</u> , to <u>April 28, 1957</u> , that I last saw the deceased alive on <u>April 27, 1957</u> , and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>Steel Pond Md.</u> DATE SIGNED							
ACTUAL SIGNATURE <u>L. P. Atwood</u> M.D.							
PHYSICIAN'S NAME (Type) <u>L. P. Atwood M.D.</u>				<u>Steel Pond Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>5/1/57</u>		<u>BETHEL CEM.</u>		<u>CHESAPEAKE CITY MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward J. Holloway</u>				ADDRESS <u>Mullington Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 3 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Ely Mulford</u>			

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BUREAU V. S.

MAY 3 1957

RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4156

CERTIFICATE OF DEATH

Reg. Dist. No. 282

04162

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>KKent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent + Queen Annes Hospital</u>		d. STREET ADDRESS <u>Depp Point Farm</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>W. Clarke Grieb</u>		4. DATE OF DEATH Month Day Year <u>April 3 1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 6, 1890</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Realtor</u>	
11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wm. L. Grieb</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Gesemyer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WW I</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>Chestertown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Cardiovascular - renal disease</u> DUE TO (c) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>5 years</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1952</u> to <u>4-3</u> <u>1957</u> , that I last saw the deceased alive on <u>4-3</u> <u>1957</u> , and that death occurred at <u>6:35</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. C. Dick</u>		ADDRESS (Street, city or town, state) <u>Chestertown, Md.</u>	
DATE SIGNED <u>4-3-57</u>		PHYSICIAN'S NAME (Type) <u>A. C. Dick</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 6, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Chestertown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Wells</u>		ADDRESS <u>Chestertown, Md.</u>	
24a. REC'D BY REGISTRAR <u>Apr. 5-57</u>		24b. REGISTRAR'S SIGNATURE <u>Clara S. Barnes</u>	

BUREAU V. S.

PR 8 1957

RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04163

4165

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH o. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. LENGTH OF STAY IN 1b 10 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD # 2 (At home)				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Harold (None) Herrmann, Jr.				4. DATE OF DEATH Apr. 4, 1957			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) 53 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerical Advertising Agency				10b. KIND OF BUSINESS OR INDUSTRY Penna		11. BIRTHPLACE (State or foreign country) USA	
13. FATHER'S NAME Harold Herrman, Sr.				14. MOTHER'S MAIDEN NAME Clara M. Whitcraft			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW 1 160-09-6710		17. INFORMANT Mrs. Grave Herrmann		Address Chestertown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio-Vascular Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH Short Several Years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. s. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Apr. 4 , 19 57 , to Apr. 4 , 19 57 , that I last saw the deceased alive on 12 57 , and that death occurred at I P. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED April 6 1957							
ACTUAL SIGNATURE Robert W. Farr M.D.				PHYSICIAN'S NAME (Type) Robert W. Farr Chestertown, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 8, 1957		22c. NAME OF CEMETERY OR CREMATORY Lawnview Cem.		22d. LOCATION (City, town, or county) (State) Rockledge, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells ADDRESS Chestertown, Md.				24a. REC'D BY REGISTRAR Apr. 5-1957		24b. REGISTRAR'S SIGNATURE Clara S. Barnes	

APR 8 1957

RECEIVED

4157 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. LENGTH OF STAY IN lb Life			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kent & Queen Anne Hospital				e. STREET ADDRESS RFD		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last John Stephen Kimble				4. DATE OF DEATH Month Day Year Apr. 30, 1957			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 17, 1953	
9. AGE (In years last birthday) 3 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Chestertown, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME J. Wesley Kimble				14. MOTHER'S MAIDEN NAME Mary Rose Moore			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Address J. Wesley Kimble Chestertown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Unknown 795.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Had I + a this am at 9 PM 4/30/57							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I and Part II, Item 18.) because family seriously objected to autopsy					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input checked="" type="checkbox"/> .							
ACTUAL SIGNATURE Robert W. Farr				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) ROBERT W. FARR				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 2 1957		22c. NAME OF CEMETERY OR CREMATORY Church Hill Cem.		22d. LOCATION (City, town, or county) (State) Church Hill, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Wells				ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR May 2-57	
				24b. REGISTRAR'S SIGNATURE Clara S. Barnes			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

MAY 6 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4158

CERTIFICATE OF DEATH

04165

Reg. Dist. No. 902

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u> <u>3 yrs</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester town</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NO Rural Chester town</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent + Queen Anne's Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Shirley</u> Middle <u>Gray</u> Last <u>Seggo</u>				4. DATE OF DEATH Month <u>April</u> Day <u>14</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 17, 1930</u>	9. AGE (In years lost birthday) <u>26</u> yrs.	IF UNDER 1 YEAR Months <u>14</u> Days <u>14</u> Hours <u>14</u> Min.		IF UNDER 24 HRS. Hours <u>14</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Leonard Brant</u>				14. MOTHER'S MAIDEN NAME <u>Susie Elizabeth Rogers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>Hospital Records - Chester town, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>592X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Nephritis (from history) chronic</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>20 days</u> <u>6 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. <u>11</u> p. m. Month <u>19</u> Day <u>19</u> Year <u>1957</u>				20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>3-25</u> , 19 <u>57</u> , to <u>4-14</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4-13</u> , 19 <u>57</u> , and that death occurred at <u>5:00 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A.C. Dick</u>				ADDRESS (Street, city or town, state) <u>Chester town, Md</u>			
PHYSICIAN'S NAME (Type) <u>A.C. Dick</u>				DATE SIGNED <u>4-14-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/16/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Asker</u>		22d. LOCATION (City, town, or county) (State) <u>N.C. Washington Cr.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Will's Wells</u>				ADDRESS <u>Chester town, Md</u>		24a. REC'D BY REGISTRAR <u>DATE 4-14-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles L. Barnes</u>			

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

BUREAU V. S.

APR 17 1957

RECEIVED

4166

CERTIFICATE OF DEATH

04166

Reg. Dist. No.

700

1. PLACE OF DEATH a. COUNTY KENT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MARYLAND b. COUNTY KENT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MILLINGTON				c. LENGTH OF STAY IN 1b 1 MONTH			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION POLLITT NURSING HOME				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Augusta Middle - Last Lockman				4. DATE OF DEATH Month APRIL Day 21 Year 1957			
5. SEX FEMALE		6. COLOR OR RACE COLORED		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN 1883	
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months 7 Days 14 Hours 15 Min.		11. BIRTHPLACE (State or foreign country) KENT Co. Md		12. CITIZEN OF WHAT COUNTRY? U.S.A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC				10b. KIND OF BUSINESS OR INDUSTRY LABOR			
13. FATHER'S NAME HORACE B. JOHNSON				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 215-20-0654			
17. INFORMANT MILBURN TILGHMAN				Address CHESTER TOWN MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stroke 443X DUE TO Hypertensive Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Stroke DUE TO (c) Stroke						INTERVAL BETWEEN ONSET AND DEATH 24 H	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) no injury			
20c. TIME OF INJURY Month, Day, Year Hour a.m. — p.m. 19				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) Millington				20g. (County) Md		20h. (State) Md	
21. I certify that I attended the deceased from Mar 27, 1957 , to Apr 21, 1957 , that I last saw the deceased alive on Apr 21, 1957 , and that death occurred at 8:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE H. H. Hamilton				ADDRESS (Street, city or town, state) Millington Md			
DATE SIGNED 4/21/57				DATE SIGNED 4/21/57			
PHYSICIAN'S NAME (Type) H. H. HAMILTON				ADDRESS MILLINGTON MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/25/57		22c. NAME OF CEMETERY OR CREMATORY JANES CEM.		22d. LOCATION (City, town, or county) (State) CHESTER TOWN MD	
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells				ADDRESS Chester Town Md			
24a. REC'D BY REGISTRAR APR 23 1957				24b. REGISTRAR'S SIGNATURE Elly Malford			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 3.

APR 23 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be checked for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4159

CERTIFICATE OF DEATH

Reg. Dist. No.

04167
201

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown			c. LENGTH OF STAY IN 1b 9 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Still Pond x 2.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent and Queen Ann Hospital				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Dora First Middle Last Weeks				4. DATE OF DEATH April 8 Month Day Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-2-68	
9. AGE (In years last birthday) 38 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Scotten				14. MOTHER'S MAIDEN NAME Sara Greenwood			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT Hosp. records		Address Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebra l vascular accident 331x DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 8 days 10 years ??	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute cholecystitis with cholelithiasis (cholecystectomy on 3-31-57)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. ft. p. m. Month, Day, Year 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3-31-57, to 4-8-57, 19 57, that I last saw the deceased alive on 4-8-57, 12 57, and that death occurred at 6:50p M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Chestertown, Maryland 4-9-57 ACTUAL SIGNATURE A.C. Dick M.D. PHYSICIAN'S NAME (Type) A.C. Dick, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/11/57		22c. NAME OF CEMETERY OR CREMATORY Still Pond Cemetery		22d. LOCATION (City, town, or county) (State) Still Pond, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Victor N. Kennedy				ADDRESS Still Pond, Md.		24a. REC'D BY REGISTRAR DATE 4/9/57	
24b. REGISTRAR'S SIGNATURE E. Kennedy Jones							

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		12-1-22		MOBILE, ALABAMA	
MARRIAGE		DATE		PLACE		NAME		DATE		PLACE	
MARRIED		1950		MOBILE, ALA.		JAMES EARL RAY		1950		MOBILE, ALA.	
OCCUPATION		DATE		PLACE		NAME		DATE		PLACE	
CONDUCTOR		1950		MOBILE, ALA.		JAMES EARL RAY		1950		MOBILE, ALA.	
CAUSE OF DEATH		DATE		PLACE		NAME		DATE		PLACE	
HEART DISEASE		1957		MOBILE, ALA.		JAMES EARL RAY		1957		MOBILE, ALA.	
MANNER OF DEATH		DATE		PLACE		NAME		DATE		PLACE	
NATURAL		1957		MOBILE, ALA.		JAMES EARL RAY		1957		MOBILE, ALA.	
SIGNATURE OF PHYSICIAN		DATE		PLACE		NAME		DATE		PLACE	
JAMES EARL RAY		1957		MOBILE, ALA.		JAMES EARL RAY		1957		MOBILE, ALA.	
SIGNATURE OF REGISTRAR		DATE		PLACE		NAME		DATE		PLACE	
JAMES EARL RAY		1957		MOBILE, ALA.		JAMES EARL RAY		1957		MOBILE, ALA.	

BUREAU V. 2

APR 12 1957

RECEIVED

James E. Ray

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04168

4160

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester town</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester town x2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent + Queen Anne's Hosp.</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First <u>Ellen</u> Middle <u>R</u> Last <u>Moffett</u>				4. DATE OF DEATH Month <u>April</u> Day <u>7</u> Year <u>1957</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 4. 1895</u>	9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>2</u>		IF UNDER 24 HRS. Hours <u>19</u> Min. <u>37</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>CECIL CO MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Robert Anderson</u>				14. MOTHER'S MAIDEN NAME <u>Mary Brogan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-03-00082</u>		17. INFORMANT <u>HOSPITAL RECORDS</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart disease (failure)</u> <u>416X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Old rheumatic disease</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2nd 49 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. <u>1</u> p. m. <u>19</u> Month, Day, Year			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2-15</u> , 19 <u>57</u> , to <u>4-6</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4-6</u> , 19 <u>57</u> , and that death occurred at <u>5 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>4-7-57</u>							
ACTUAL SIGNATURE <u>A. C. Dick</u> M.D.				CHESTER TOWN, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/9/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CHESTER CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>Chester town Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>St. Willis Wells</u> ADDRESS <u>Chester town Md</u>				24a. REC'D BY REGISTRAR <u>Apr. 9-1957</u>		24b. REGISTRAR'S SIGNATURE <u>Clara S. Barnes</u>	

CERTIFICATE OF DEATH

Form No. 10

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

1. NAME OF DECEASED <i>JOHN J. SMITH</i>		2. SEX <i>MALE</i>		3. AGE <i>65</i>	
4. PLACE OF BIRTH <i>NEW YORK</i>		5. DATE OF BIRTH <i>1890</i>		6. PLACE OF DEATH <i>BALTIMORE</i>	
7. OCCUPATION <i>CLERK</i>		8. CAUSE OF DEATH <i>HEART DISEASE</i>		9. MANNER OF DEATH <i>NATURAL</i>	
10. DATE OF DEATH <i>APR 10 1957</i>		11. TIME OF DEATH <i>10:00 AM</i>		12. SIGNATURE OF DECEASED <i>[Signature]</i>	
13. SIGNATURE OF WITNESS <i>[Signature]</i>		14. SIGNATURE OF PHYSICIAN <i>[Signature]</i>		15. SIGNATURE OF REGISTRAR <i>[Signature]</i>	
16. PLACE OF INTERMENT <i>ST. MARY'S CATHEDRAL</i>		17. DATE OF INTERMENT <i>APR 12 1957</i>		18. TIME OF INTERMENT <i>11:00 AM</i>	
19. NAME OF FUNERAL HOME <i>JOHN J. SMITH & SONS</i>		20. ADDRESS OF FUNERAL HOME <i>123 BALTIMORE ST.</i>		21. PHONE NUMBER OF FUNERAL HOME <i>555-1234</i>	
22. NAME OF NEXT OF KIN <i>MRS. J. SMITH</i>		23. ADDRESS OF NEXT OF KIN <i>456 PINE ST.</i>		24. PHONE NUMBER OF NEXT OF KIN <i>555-5678</i>	
25. NAME OF SURVIVING SPOUSE <i>MRS. J. SMITH</i>		26. ADDRESS OF SURVIVING SPOUSE <i>456 PINE ST.</i>		27. PHONE NUMBER OF SURVIVING SPOUSE <i>555-5678</i>	
28. NAME OF SURVIVING CHILD <i>JOHN J. SMITH JR.</i>		29. ADDRESS OF SURVIVING CHILD <i>456 PINE ST.</i>		30. PHONE NUMBER OF SURVIVING CHILD <i>555-5678</i>	
31. NAME OF SURVIVING PARENT <i>MRS. J. SMITH</i>		32. ADDRESS OF SURVIVING PARENT <i>456 PINE ST.</i>		33. PHONE NUMBER OF SURVIVING PARENT <i>555-5678</i>	
34. NAME OF SURVIVING SIBLING <i>JOHN J. SMITH JR.</i>		35. ADDRESS OF SURVIVING SIBLING <i>456 PINE ST.</i>		36. PHONE NUMBER OF SURVIVING SIBLING <i>555-5678</i>	
37. NAME OF SURVIVING GRANDPARENT <i>MRS. J. SMITH</i>		38. ADDRESS OF SURVIVING GRANDPARENT <i>456 PINE ST.</i>		39. PHONE NUMBER OF SURVIVING GRANDPARENT <i>555-5678</i>	
40. NAME OF SURVIVING GRANDSIBLING <i>JOHN J. SMITH JR.</i>		41. ADDRESS OF SURVIVING GRANDSIBLING <i>456 PINE ST.</i>		42. PHONE NUMBER OF SURVIVING GRANDSIBLING <i>555-5678</i>	
43. NAME OF SURVIVING GREAT-GRANDPARENT <i>MRS. J. SMITH</i>		44. ADDRESS OF SURVIVING GREAT-GRANDPARENT <i>456 PINE ST.</i>		45. PHONE NUMBER OF SURVIVING GREAT-GRANDPARENT <i>555-5678</i>	
46. NAME OF SURVIVING GREAT-GRANDSIBLING <i>JOHN J. SMITH JR.</i>		47. ADDRESS OF SURVIVING GREAT-GRANDSIBLING <i>456 PINE ST.</i>		48. PHONE NUMBER OF SURVIVING GREAT-GRANDSIBLING <i>555-5678</i>	
49. NAME OF SURVIVING GREAT-GRANDPARENT <i>MRS. J. SMITH</i>		50. ADDRESS OF SURVIVING GREAT-GRANDPARENT <i>456 PINE ST.</i>		51. PHONE NUMBER OF SURVIVING GREAT-GRANDPARENT <i>555-5678</i>	
52. NAME OF SURVIVING GREAT-GRANDSIBLING <i>JOHN J. SMITH JR.</i>		53. ADDRESS OF SURVIVING GREAT-GRANDSIBLING <i>456 PINE ST.</i>		54. PHONE NUMBER OF SURVIVING GREAT-GRANDSIBLING <i>555-5678</i>	
55. NAME OF SURVIVING GREAT-GRANDPARENT <i>MRS. J. SMITH</i>		56. ADDRESS OF SURVIVING GREAT-GRANDPARENT <i>456 PINE ST.</i>		57. PHONE NUMBER OF SURVIVING GREAT-GRANDPARENT <i>555-5678</i>	
58. NAME OF SURVIVING GREAT-GRANDSIBLING <i>JOHN J. SMITH JR.</i>		59. ADDRESS OF SURVIVING GREAT-GRANDSIBLING <i>456 PINE ST.</i>		60. PHONE NUMBER OF SURVIVING GREAT-GRANDSIBLING <i>555-5678</i>	
61. NAME OF SURVIVING GREAT-GRANDPARENT <i>MRS. J. SMITH</i>		62. ADDRESS OF SURVIVING GREAT-GRANDPARENT <i>456 PINE ST.</i>		63. PHONE NUMBER OF SURVIVING GREAT-GRANDPARENT <i>555-5678</i>	
64. NAME OF SURVIVING GREAT-GRANDSIBLING <i>JOHN J. SMITH JR.</i>		65. ADDRESS OF SURVIVING GREAT-GRANDSIBLING <i>456 PINE ST.</i>		66. PHONE NUMBER OF SURVIVING GREAT-GRANDSIBLING <i>555-5678</i>	
67. NAME OF SURVIVING GREAT-GRANDPARENT <i>MRS. J. SMITH</i>		68. ADDRESS OF SURVIVING GREAT-GRANDPARENT <i>456 PINE ST.</i>		69. PHONE NUMBER OF SURVIVING GREAT-GRANDPARENT <i>555-5678</i>	
70. NAME OF SURVIVING GREAT-GRANDSIBLING <i>JOHN J. SMITH JR.</i>		71. ADDRESS OF SURVIVING GREAT-GRANDSIBLING <i>456 PINE ST.</i>		72. PHONE NUMBER OF SURVIVING GREAT-GRANDSIBLING <i>555-5678</i>	
73. NAME OF SURVIVING GREAT-GRANDPARENT <i>MRS. J. SMITH</i>		74. ADDRESS OF SURVIVING GREAT-GRANDPARENT <i>456 PINE ST.</i>		75. PHONE NUMBER OF SURVIVING GREAT-GRANDPARENT <i>555-5678</i>	
76. NAME OF SURVIVING GREAT-GRANDSIBLING <i>JOHN J. SMITH JR.</i>		77. ADDRESS OF SURVIVING GREAT-GRANDSIBLING <i>456 PINE ST.</i>		78. PHONE NUMBER OF SURVIVING GREAT-GRANDSIBLING <i>555-5678</i>	
79. NAME OF SURVIVING GREAT-GRANDPARENT <i>MRS. J. SMITH</i>		80. ADDRESS OF SURVIVING GREAT-GRANDPARENT <i>456 PINE ST.</i>		81. PHONE NUMBER OF SURVIVING GREAT-GRANDPARENT <i>555-5678</i>	
82. NAME OF SURVIVING GREAT-GRANDSIBLING <i>JOHN J. SMITH JR.</i>		83. ADDRESS OF SURVIVING GREAT-GRANDSIBLING <i>456 PINE ST.</i>		84. PHONE NUMBER OF SURVIVING GREAT-GRANDSIBLING <i>555-5678</i>	
85. NAME OF SURVIVING GREAT-GRANDPARENT <i>MRS. J. SMITH</i>		86. ADDRESS OF SURVIVING GREAT-GRANDPARENT <i>456 PINE ST.</i>		87. PHONE NUMBER OF SURVIVING GREAT-GRANDPARENT <i>555-5678</i>	
88. NAME OF SURVIVING GREAT-GRANDSIBLING <i>JOHN J. SMITH JR.</i>		89. ADDRESS OF SURVIVING GREAT-GRANDSIBLING <i>456 PINE ST.</i>		90. PHONE NUMBER OF SURVIVING GREAT-GRANDSIBLING <i>555-5678</i>	
91. NAME OF SURVIVING GREAT-GRANDPARENT <i>MRS. J. SMITH</i>		92. ADDRESS OF SURVIVING GREAT-GRANDPARENT <i>456 PINE ST.</i>		93. PHONE NUMBER OF SURVIVING GREAT-GRANDPARENT <i>555-5678</i>	
94. NAME OF SURVIVING GREAT-GRANDSIBLING <i>JOHN J. SMITH JR.</i>		95. ADDRESS OF SURVIVING GREAT-GRANDSIBLING <i>456 PINE ST.</i>		96. PHONE NUMBER OF SURVIVING GREAT-GRANDSIBLING <i>555-5678</i>	
97. NAME OF SURVIVING GREAT-GRANDPARENT <i>MRS. J. SMITH</i>		98. ADDRESS OF SURVIVING GREAT-GRANDPARENT <i>456 PINE ST.</i>		99. PHONE NUMBER OF SURVIVING GREAT-GRANDPARENT <i>555-5678</i>	
100. NAME OF SURVIVING GREAT-GRANDSIBLING <i>JOHN J. SMITH JR.</i>		101. ADDRESS OF SURVIVING GREAT-GRANDSIBLING <i>456 PINE ST.</i>		102. PHONE NUMBER OF SURVIVING GREAT-GRANDSIBLING <i>555-5678</i>	

BUREAU V. 3

APR 10 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04169

4161

CERTIFICATE OF DEATH

Reg. Dist. No. 2021

1. PLACE OF DEATH a. COUNTY <u>KENT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>KENT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESTERTOWN</u>		c. LENGTH OF STAY IN 1b <u>2 weeks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent & Queen Anne's Hosp.</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JARRETT TILDEN PRICE</u>		4. DATE OF DEATH Month Day Year <u>APR 5 1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 18, 1874</u>
9. AGE (In years lost birthday) <u>82</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARE-TAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wm Price</u>		14. MOTHER'S MAIDEN NAME <u>Sara Marsh</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>0</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>HOSPITAL RECORD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR ACCIDENT</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<u>CARCINOMA OF PANCREAS AND COLON</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MAR 24, 1957</u> to <u>APR 5, 1957</u> , that I last saw the deceased alive on <u>APR 5, 1957</u> , and that death occurred at <u>9:30</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>CHESTERTOWN, Md</u> <u>4-5-57</u> ACTUAL SIGNATURE <u>A. T. Keefe</u> M.D. PHYSICIAN'S NAME (Type) <u>A. T. KEEFE, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/8/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rock Hall</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u>		24a. REC'D BY REGISTRAR <u>April 11-1957</u>	
ADDRESS <u>Church Hill Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Clara L. Barnes</u>	

CERTIFICATE OF DEATH

DATE OF DEATH		PLACE OF DEATH	
TIME OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		DISEASE OR INJURY	
AGE		SEX	
RACE		RELIGION	
EDUCATION		OCCUPATION	
MARITAL STATUS		PREVIOUS ILLNESS	
DATE OF BIRTH		PLACE OF BIRTH	
PARENTS		SIBLINGS	
GRANDPARENTS		OTHER RELATIVES	
DEATH CERTIFICATE NO.		REGISTERED	
DATE OF REGISTRATION		PLACE OF REGISTRATION	
SIGNATURE OF REGISTRAR		OFFICIAL SEAL	
DATE OF SIGNATURE		PLACE OF SIGNATURE	
SIGNATURE OF DECEASED		OFFICIAL SEAL	
DATE OF SIGNATURE		PLACE OF SIGNATURE	
SIGNATURE OF WITNESSES		OFFICIAL SEAL	
DATE OF SIGNATURE		PLACE OF SIGNATURE	
SIGNATURE OF CORONER		OFFICIAL SEAL	
DATE OF SIGNATURE		PLACE OF SIGNATURE	
SIGNATURE OF JUDGE		OFFICIAL SEAL	
DATE OF SIGNATURE		PLACE OF SIGNATURE	
SIGNATURE OF CLERK		OFFICIAL SEAL	
DATE OF SIGNATURE		PLACE OF SIGNATURE	
SIGNATURE OF NOTARY		OFFICIAL SEAL	
DATE OF SIGNATURE		PLACE OF SIGNATURE	
SIGNATURE OF ATTORNEY		OFFICIAL SEAL	
DATE OF SIGNATURE		PLACE OF SIGNATURE	
SIGNATURE OF PHYSICIAN		OFFICIAL SEAL	
DATE OF SIGNATURE		PLACE OF SIGNATURE	
SIGNATURE OF NURSE		OFFICIAL SEAL	
DATE OF SIGNATURE		PLACE OF SIGNATURE	
SIGNATURE OF CHURCH		OFFICIAL SEAL	
DATE OF SIGNATURE		PLACE OF SIGNATURE	
SIGNATURE OF SCHOOL		OFFICIAL SEAL	
DATE OF SIGNATURE		PLACE OF SIGNATURE	
SIGNATURE OF EMPLOYER		OFFICIAL SEAL	
DATE OF SIGNATURE		PLACE OF SIGNATURE	
SIGNATURE OF FRIEND		OFFICIAL SEAL	
DATE OF SIGNATURE		PLACE OF SIGNATURE	
SIGNATURE OF NEIGHBOR		OFFICIAL SEAL	
DATE OF SIGNATURE		PLACE OF SIGNATURE	
SIGNATURE OF OTHER		OFFICIAL SEAL	
DATE OF SIGNATURE		PLACE OF SIGNATURE	

BUREAU V. S.

APR 12 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4162

CERTIFICATE OF DEATH

Reg. Dist. No.

04170
202

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 Chestertown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Annes Hosp.				d. STREET ADDRESS 1 110 N. Queen St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last J. RAYMOND SIMPERS				4. DATE OF DEATH Month Day Year Apr. 11 1957			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 19 1879		9. AGE (In years last birthday) yrs. 78	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) accountant		10b. KIND OF BUSINESS OR INDUSTRY bookkeeping		11. BIRTHPLACE (State or foreign country) Chestertown Kent Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John H. Simpeters				14. MOTHER'S MAIDEN NAME Mary Anne Hanes Vanort			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address F. Vanort Simpeters, Chestertown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory collapse 153x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Parglytic ileus and DUE TO Operation for cancer of large bowel and (c) cerebral vascular accident						INTERVAL BETWEEN ONSET AND DEATH 4 days 7 days 15 days 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-26, 19 57, to 4-11, 19 57, that I last saw the deceased alive on 4-11, 19 57, and that death occurred at 9:15p M, from the causes and on the date stated above.							
ACTUAL SIGNATURE A. C. DICK				ADDRESS (Street, city or town, state) Chestertown, Md.		DATE SIGNED 4-13-57	
PHYSICIAN'S NAME (Type) A. C. DICK				Chestertown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 14/57		22c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		22d. LOCATION (City, town, or county) (State) Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams, Chestertown, Md.				24a. REC'D BY REGISTRAR Apr. 15-1957		24b. REGISTRAR'S SIGNATURE Charles S. Barnes	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JOHN H. STANLEY		2. SEX Male		3. AGE 45		4. DATE OF BIRTH 1912		5. PLACE OF BIRTH BALTIMORE, MARYLAND	
6. OCCUPATION None		7. MARITAL STATUS Single		8. COLOR White		9. RELIGION None		10. EDUCATION None	
11. CAUSE OF DEATH Heart Disease		12. MANNER OF DEATH Natural		13. PLACE OF DEATH Home		14. DATE OF DEATH 1957		15. TIME OF DEATH 10:00 AM	
16. SIGNATURE OF PHYSICIAN J. H. STANLEY		17. SIGNATURE OF WITNESSES J. H. STANLEY		18. SIGNATURE OF DECEASED J. H. STANLEY		19. SIGNATURE OF FUNERAL HOME J. H. STANLEY		20. SIGNATURE OF REGISTRAR J. H. STANLEY	

BUREAU V. S.

APR 17 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4163

CERTIFICATE OF DEATH

Reg. Dist. No.

04171
20/1

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. LENGTH OF STAY IN 1b 1 hour			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Annes				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) WILSON First Isaac Middle Wilson Last Wilson				4. DATE OF DEATH Month April Day 13 Year 1957			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 18, 1894	9. AGE (In years lost birthday) yrs. 63	IF UNDER 1 YEAR Months 13 Days 15 Hours 57	IF UNDER 24 HRS. Months 13 Days 15 Hours 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Cannery		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Wilson				14. MOTHER'S MAIDEN NAME Nancy Geoms			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 217-14-8217		17. INFORMANT Wife & hospital records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial hemorrhage 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterial hypertension DUE TO (c) _____ several years						INTERVAL BETWEEN ONSET AND DEATH 3 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardiac arrhythmia—supraventricular & ventricular premature beats in runs and separately						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. 1 p. m. Month, Day, Year 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/26/56 , 19____, to 4/13 , 19____, that I last saw the deceased alive on 4/13/57 , 19____, and that death occurred at 1:50 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Robert . Farr M.D. Chestertown, Md.				PHYSICIAN'S NAME (Type) Robert . Farr			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-16-57		22c. NAME OF CEMETERY OR CREMATORY MT. OLIVE CEMTY		22d. LOCATION (City, town, or county) (State) WORTON MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Victor N. Kennedy ADDRESS STILL POND, MD.				24a. REC'D BY REGISTRAR DATE 4/15/57		24b. REGISTRAR'S SIGNATURE E. Kennedy	

CERTIFICATE OF DEATH

NAME OF DECEASED		MARRIAGE	
DATE OF BIRTH		DATE OF MARRIAGE	
PLACE OF BIRTH		PLACE OF MARRIAGE	
OCCUPATION		OCCUPATION	
EDUCATION		EDUCATION	
RELIGION		RELIGION	
CAUSE OF DEATH		CAUSE OF DEATH	
PLACE OF DEATH		PLACE OF DEATH	
DATE OF DEATH		DATE OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN	
SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
SIGNATURE OF DECEASED		SIGNATURE OF DECEASED	
SIGNATURE OF FUNERAL HOME		SIGNATURE OF FUNERAL HOME	
SIGNATURE OF BURIAL PLACE		SIGNATURE OF BURIAL PLACE	
SIGNATURE OF STATE DEPARTMENT OF HEALTH		SIGNATURE OF STATE DEPARTMENT OF HEALTH	

217-14-827

NO

BUREAU V. S.

APR 19 1957

RECEIVED

WORTHEN

MT OLIVE CEMT

BURIAL 4-10-57

DECEASED'S NAME, STREET, CITY, STATE, ZIP